Opening Statement of the Honorable Joseph R. Pitts
Subcommittee on Health
Hearing on "Medicare Post Acute Care Delivery and Options to Improve It"
April 16, 2015

(As Prepared for Delivery)

Over the past several years, central to this committee's agenda, has been our interest in understanding and responding to the need to modernize Medicare's financing and payment structures. Today's hearing will give Members and stakeholders an opportunity to examine the current state of post-acute care (PAC) for Medicare beneficiaries and discuss ways it can be improved.

Post-acute care is care that is provided to individuals who need additional help recuperating from an acute illness or serious medical procedure, usually after discharge from hospital care.

Post-acute care providers – such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), home health agencies (HHAs), and hospices – are reimbursed by Medicare with different payment systems which were originally designed to focus on a phase of a patient's illness in a specific site of service. As a result, payments across post-acute care settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

According to the Medicare Payment Advisory Commission (MedPAC), Medicare's payments to PAC providers totaled $59 billion in 2013. For patients who are hospitalized for exacerbations of chronic conditions, such as congestive heart failure, Medicare spends nearly as much on post-acute care and readmissions in the first 30 days after a patient is discharged, as it does for the initial hospital admission. Medicare payments for post-acute care have grown faster than most other categories of spending.

For example, total Medicare spending for patients hospitalized with myocardial infarction, congestive heart failure, or hip fracture grew by 1.5 to 2.0% each year between 1994 and 2009, while spending on post-acute care for those patients grew by 4.5 to 8.5% per year.

There are many opportunities for the Medicare program to save taxpayers' dollars and improve seniors' quality of care through better management of post-acute care. One way is to make sure patients are treated in the most cost-effective, clinically appropriate setting.

The current model has significant reimbursement disparities for treating the same condition. For example, for patients hospitalized with congestive heart failure in 2008, Medicare paid about $2,500 in the 30 days after discharge for each patient who received home health care, as compared with $10,700 for those admitted to a SNF, and $15,000 for those cared for in a rehabilitation hospital.

Our colleague, Rep. Dave McKinley, has had a long interest in this subject and has sponsored legislation along with Reps. Tom Price and John McNerney to provide bundled payments for post-acute care services under Medicare. His bill is H.R. 1458, the "Bundling and Coordinating Post-Acute Care Act of 2015," and is also known as "BACPAC" Act of 2015.

This bill is designed to foster the delivery of high-quality post-acute care services in the most cost-effective manner, while preserving the ability of patients, with guidance from their physician, to select their preferred provider of post-acute care services. This is the type of legislation that has the potential to promote healthy competition among PAC providers on the basis of quality, cost, accountability and customer service while advancing innovation in care coordination, medication management, and hospitalization avoidance.

Given the potential proposals like this have to reward quality and achieve savings for beneficiaries while strengthening the sustainability of the Medicare program, I am glad Congress is examining post-acute issues in our hearing.

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